Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON PAIN & INJURY
604 PENNY LANE
FRIENDSWOOD TEXAS 77546

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
METROPOLITAN TRANSIT AUTHORITY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-0913-01

MFDR Date Received
November 12, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All timed codes accounted for in documentation."

Amount in Dispute: $720.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor is specifically requesting dispute resolution for CPT code 97110 – Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises. The requestor billed for 6 units of 97110 in the amount of $216.00 for each of the service dates listed above. One unite of 97110 was recommended for payment, per day, in the amount of $36.00. The other 4 units were denied as documentation did not support time spent... The respondent maintains its position that one unit (out of six) of CPT code 97110 was reimbursed correctly in accordance with the TDI-DWC rule 134.203."

Response Submitted by: STARR Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2010, July 16, 2010, July 20, 2010 and July 22, 2010	97110	$720.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Per 28 Texas Administrative Code §134.203 sets out the fee guideline reimbursement for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 9, 2010
- 16 – Documentation does not support billed services

Explanation of benefits dated October 18, 2010
- 16 – Documentation does not support billed services
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Did the requestor submit documentation to support the billing of 5 units of CPT code 97110 per disputed date of service?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 ""(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
    - CPT code 97110 is reimbursement at 15 minute increments. CMS requires that the total treatment minutes, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented.
    - Review of the documentation submitted by the requestor to include the "Amended" documentation, did include documentation to support the additional 5 units for dates of service July 15, 2010, July 16, 2010, July 20, 2010 and July 22, 2010.
    - Additional reimbursement for the disputed charges is therefore not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 14, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.